EXHIBIT 15

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REQUEST FOR MEDICAL INFORMATION
(Revised effective 11/27/12)

Employee's Name: RONALD GONZALEZ

TO BE COMPLETED BY EMPLOYEE'S MEDICAL PROVIDER

A. Instructions

The employee listed above has submitted a request for a job-related accommodation arising out of a medical condition. The Genetic Information Nondiscrimination Act of 2008 prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. In order for UPS to assess the employee's request, please complete the following information and return it to me in the enclosed envelope or FAX it to me at:

Patricia Lorio
10881 West Lowell Ave.
Suite 300
Overland Park, KS 66210
Phone: 1-855-UPS-HRSC (1-855-877-4772)
FAX: 1-877-251-6166

If you have any questions relating to the completion of this form or need clarification of any of the information requested, please call the Occupational Health Supervisor at the number listed above. If additional space is necessary, please feel free to attach additional sheets. Although it is important that you complete this entire form, you are also welcome to include or attach additional information that you or the employee believes may assist the Company in assessing the employee's request for accommodation. UPS appreciates your cooperation and assistance.

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B. Requested Information

Attached to this form is a description of the essential functions of the employee's current position with UPS. If you have any questions about the description of the essential functions of the employee's position, please contact the Occupational Health Supervisor for clarification or explanation. After reviewing this description and evaluating the employee, please answer the following questions.

1. Is the employee currently able to perform all of the functions of his/her position?

____ Yes ✓ No

2. If the answer to Question 1 is "no," using the enclosed essential job functions form, please identify the specific function(s) of the position that the employee is unable to perform.

unable to do continuous repetitive movements of upper extremities; decreased ability to make decisions due to medication prescribed.

3. Please identify the diagnosis or describe the condition that precludes or impairs the employee's ability to perform the specific job function(s) identified in response to Question 2.

decreased range of motion of upper extremity and decreased ability of concentration
729.5 arm Pain
Depression - per psychiatrist

a. For each diagnosis or condition identified in Question 3 above, describe in detail the degree or extent of the job restrictions and state the known or expected duration of the job restrictions (e.g., employee's 40-pound lifting restriction is permanent;

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employee cannot work more than 4 hours per day and/or on a particular shift for two weeks; employee cannot work in an environment over 80 degrees for 3 months etc.). If the condition is episodic, please indicate both the historic and anticipated future frequency.

Patient is reasonable unable to work for 4 hours or greater due to inability to do repetitive motions, diminished sleep cycles, have increased pain perception, patient continues on medication for pain, cannot lift greater than 5 lbs.

b. For each job restriction described in Question 3(a) above, describe the activities that the employee can perform within the restriction (e.g., although the employee cannot lift over 40 pounds, she can lift 10 pounds frequently and 25 to 40 pounds occasionally).

would like to consider RTW with accomadations after 3/5/14, possible 4 hours a day, no lifting over 5 lbs is available.

4. Questions 1 through 3 above focus on the employee's ability to work. Do any of the diagnoses or conditions identified in response to Question 3 substantially limit the employee's ability to perform any major life activities other than working, such as caring for him/herself, performing manual tasks, walking, seeing, hearing, speaking, breathing, reproducing, learning, eating, sleeping, standing, lifting, bending, reading, concentrating, thinking, communicating, etc.?

✓ Yes ____ No

5. If the answer to Question 4 is "yes," please identify all of the major life activities

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affected by the diagnosis or condition and describe the manner in which the diagnosis or condition limits each activity.

limitation in sleep, lifting, sitting, standing, repetitive motions of upper extremities, decreased concentration and ability to make decisions.

6. In the space provided below, please identify any tests or other diagnostic tools that were used to determine this employee's abilities or the nature of his/her impairment, including the names of the tests or diagnostic tools and the dates on which any such tests or tools were administered to the employee.

N/A

Name: _____ Date: _____
(Please Print)

Address: _____

_____

Phone: (_____) _____

FAX: (_____) _____

Signature: _____

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